Tulare County 2015 Health Plan Enrollment Form
MID-YEAR CHANGE

Reset Form

MUST submit to HR&D-Benefits within 30 days of the event date

Last Name:	First Name:	MI:	Employee ID#:	Social Security #:

Address:	Phone Number:	Date of Birth:	Gender:

Qualifying Status Change:

- ☐ Marriage or ☐ Divorce
- ☐ Birth or ☐ Adoption
- ☐ Dependent Loss of Eligibility
- ☐ Medicare Entitlement
- ☐ Gain/Loss of Medi-Cal
- ☐ Employment Change ☐ **Spouse** ☐ **Self**
- ☐ Moved Out of Service Area
- ☐ Military Duty/Deployed
- ☐ Reduction of Hours
- ☐ Leave of Absence*
- ☐ Return to Work
- ☐ Death

Requested Change:

- ☐ New Enrollment
- ☐ Add Dependent(s)
- ☐ Delete Dependent(s)
- ☐ Suspend Coverage*
- ☐ Reinstate Coverage
- ☐ Cancel Coverage
- ☐ Name Change
  Former Name: _____

Event Date: _____/_____/_____

- Effective date of coverage to enroll, reinstate, or add coverage is the first day of month following the event date or date of receipt; whichever is later.
- Effective date of coverage to delete, suspend, or cancel coverage is the last day of the month following the event date or date of receipt; whichever is later.
- Effective date to add a child due to birth is the first day of the month following the date of the birth.

ALL CHANGE REQUESTS ARE SUBJECT TO ELIGIBILITY REVIEW

Health Plan Options (Includes Medical, Vision, Dental & Prescription)

A. Medical Plans (Select One)

- ☐ 1. Anthem Blue Cross HMO *(Must select Primary Care Physician)*
- ☐ 2. Anthem Blue Cross $0 Deductible PPO Plan
- ☐ 3. Anthem Blue Cross $500 Deductible PPO Plan
- ☐ 4. Anthem Blue Cross $1000 Deductible PPO Plan
- ☐ 5. Anthem Blue Cross $2500 High Deductible PPO Plan*
  ☐ * **Health Savings Account** Amount $_____
- ☐ 6. Kaiser Permanente HMO Deductible Plan
- ☐ 7. Kaiser Permanente HMO Traditional Plan

Group #:_____

Enrollment Unit #_____

C. Coverage Level

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family

D. Members Enrolling

- ☐ Myself
- ☐ Legal Spouse
- ☐ Registered Domestic Partner
- ☐ Child(ren)

B. Dental Plans (Select One)

- ☐ 1. Delta Dental PPO
- ☐ 2. DeltaCare USA HMO *(Must select a Primary Care Physician)*

DEPENDENTS: Name	Relationship	Date of Birth	Social Security #	Gender	Add	Delete
1.					☐	☐
2.					☐	☐
3.					☐	☐
4.					☐	☐

☐ ***I understand that I will be required to provide documentation that verifies the relationship of any dependent(s) I enroll on the plan***

MEDICARE: Do you or any of your dependents have Medicare? ☐ NO ☐ YES - If yes, please provide a copy of your Medicare Card(s)

YOU: ☐ PART A ☐ PART B ☐ BOTH Effective Date:_____ Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ ESRD

DEPENDENT: ☐ PART A ☐ PART B ☐ BOTH Effective Date:_____ Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ ESRD

***LEAVE OF ABSENCE – SUSPEND COVERAGE:**

☐ I acknowledge that my employer has explained the coverage available to me during my Leave of Absence and that I have every right to remain enrolled in this coverage and I have decided to SUSPEND my coverage. _____ *Initial*

☐ I understand that upon my return-to-work I must submit a Change Request Form to reinstate my coverage or my coverage will remain suspended, and I will forfeit my benefit amount for the remainder of the plan year.

Participant Signature:_____ **Date:**_____

ELECTION AUTHORIZATION: I understand that as a participant in the COUNTY OF TULARE's Flexible Benefit Plan, my plan selection cannot be changed until Open Enrollment. Dependent deletions and additions can only be made during the plan year if I have a qualifying family status change as defined in IRS regulations and the COUNTY OF TULARE Flexible Benefit Plan. Qualifying family status changes **must be reported within 30 days of the event and accompanied by the appropriate documentation.** I also understand that any contribution I am required to make for my benefit selections will be taken from my earnings prior to the deduction of payroll taxes as allowed by State and Federal laws.

I have read and understand the binding arbitration and plan disclosure information printed on the reverse side of this form. I understand my acceptance of these provisions is a requirement to enroll in the health plan. My signature below indicates my agreement to the terms and conditions required by the insurance carriers.

All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or my coverage being rescinded.

Participant Signature: _____ **Date:** _____

For Office Use Only:

☐ Approved _____ ☐ Supporting Docs Rcvd:_____ ☐ Denied_____Reason_____

Employee ID# _____ BU_____ Event Date: _____ Coverage Eff Date: _____ PR Ded / Ben Amt Date: _____

Keyed Date: _____ By_____Comments:_____

DISCLOSURE INFORMATION

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of* Coverage.

_____

Signature Required for Kaiser Permanente Plan

_____

Date

ANTHEM BLUE CROSS BINDING ARBITRATION AGREEMENT

ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND MEDICAL MALPRACTICE CLAIMS.

By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

Signature: _____

Date:_____